UW Cytogenetic Services

Wisconsin State Laboratory of Hygiene
University of Wisconsin-Madison
465 Henry Mall, Rm 419, Madison, WI 53706
Phone: 608.262.0402 Fax: 608.265.7818

Request for Release of DNA Sample

Date of request (mm/dd/yyyy):_______________________

Depositor Name:____
Street Address:____
City:____
State:____
Zip code:____

Requested DNA amount in micrograms:______________

Please send the above amount of DNA from my banked DNA samples to the following testing facility or medical professional at the following address:

Testing facility or medical professional:____________________________________
Street Address:____
City:____
State:____
Zip code:____
Phone: (   )_________________________

☐ Facility paperwork included

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I authorize the release of a sample of DNA from ______________________________, (the depositor), to the above mentioned diagnostic laboratory or medical professional and understand the implications of the DNA testing to be completed.

____
(signature of depositor or subsequent owner of DNA)

To be completed by a physician or genetic counselor:
I have explained the DNA testing to be completed at the diagnostic facility specified above to the depositor and/or his/her legal guardian or owner of the banked DNA sample and have answered all this individual's questions.

____
Print name   Signature   Date

Address:____